Local Health Department Ebola Weekly Update Call

Minutes

November 05, 2014
10:00 AM to 11:00 AM

Cheryl Starling: Welcome to our local health department partners for the weekly Ebola update with CDPH and other people on the call.

Today, just a reminder of the logistics, we may at some point open it up for discussion as needed. But questions and answer for the most part will come at the end.

If you want to ask a question, as (Julie) said, please hit Star 1. But please leave your name - full name and title and organization that you're with.

As we want to make sure our local health partners are the first to be able to ask questions and answers during this session.

If you are another healthcare provider or member of healthcare organizations, the local health department - excuse me. The local hospital call is from 11:00 to 12:00.

And we invite you to ask your questions at that time. At this time I'd like to hand it over to Dr. (Gil Chavez), who will talk to us about the updates.

Dr. (Gil Chavez): Yes, thank you very much Cheryl, and good morning everyone. I'll be very brief. The situation in national - internationally appears to be moving in what seems like the right direction.

Some of the countries that have been heavily affected are beginning to see what appears to be some tapering off of the number of cases. Of course, nobody is saying that any countries out of the woods yet.

But certainly appears that the level of activity in Liberia, Syria, (unintelligible) and Guinea it's a list longer (unintelligible). So we're hopeful that that trend continues.

And that soon enough they can have that situation under better control. So at a minimum we can say that it's not going expediently as it seemed to have been doing earlier on.

The other thing that I want to point out is that from an international perspective, there's been some interesting debate about some countries.

That have enacted what appears to be very strict travel restrictions for travelers from those countries. We've heard about Australia pretty much closing down their boarders to any traveler from those countries.

And we heard this week that Canada is doing the same thing. In the US, we have model that appears to be working quite well.

Whereas you know, the Department of Homeland Security is asking that all travelers to this country come from - through five specific airports if they are starting their travel in the three affected countries.

That is giving us a very, very good head up on the number of people that are arriving in each individual state that are coming from those three nations.

Whether they either live there - whether they were there for work or for visiting - based on that as you know, we are providing to you lists on a regular basis of individuals in your jurisdiction that recently arrived or are to arrive from those areas.

One thing that has come up as a question is, you know, just how does this work out? And do we ever get notifications ahead of time?

So wanted to point out that (unintelligible) has done what I consider to be a very good way of dealing with this - that if they have what's considered low risk travelers based on their own assessment, they notify us by via APX.

And then we immediately notify you via phone and email. So that you know that you have a traveler coming to you. And you have the contact information.

If the traveler is deemed to be some risk or high risk by CDC, they will actually contact us before the individual actually arrives in California.

So we can make preparations in order to be able to handle that patient as he or she arrives. In California at the moment, we have individuals that have returned from those three affected countries.

In 14 different counties - so 14 of you have already had experience in monitoring this individual. And one thing that is of interest, is that has we have been doing this now for quite some time - several weeks.

Some of the earlier arrivals to California are actually now meeting their 21 day monitoring. And actually graduating from monitoring - so we're getting to a point where we not been getting new incoming travelers daily.

But travelers are also dropping out of the monitoring list. So hopefully we get a point where we can be pretty stable in terms of the numbers we have - seems that we are getting on average a couple of travelers coming in a day.

And so obviously overtime, those same travelers will be coming off the monitoring list. So I think everybody that is involved in the active monitoring at the local level has a very good grip on.

We had a conference call with those counties earlier this week. Had some lessons learned and interesting conversations with each other as to how the monitoring is playing out.

And we're very confident that every one of those counties is doing a perfect job in terms of doing the active monitoring of these patients.

One thing that CDC started doing this week that I wanted you to be aware of, is that their obviously very concerned in assuring that we are doing the right thing.

And starting - following up with us on a weekly basis to - actually, on a daily basis - but they need a weekly report on just how many patients we are monitoring.

And what kinds of monitoring we are doing with those patients. Particularly the ones that are high risk. They are really encouraging us to be doing face to face monitoring - including Skype.

For those patients that are deemed to be in the same or high risk category. Thankfully in California we only have a one such case as of today. I think I'm going to stop here and turn over to Cheryl for here to continue.

And we'll be here to answer any questions you may have. We keep on hoping that these meetings are lists of us talking with you - and more of you asking

your questions and us being able to provide whatever information you may need - thank you.

Cheryl Starling: Thank you Dr. (Chavez). Dr. (Chapman) and Ms. (unintelligible), will you talk to us about the isolation and evaluation orders and quarantine?

Dr. (Ron Chapman): Sure. Thank you. This is (Ron Chapman). And before I do that, I do want to just follow up on (Gil)'s last - about the reporting the CDC. That's a national effort.

I just want to emphasize, they're not just asking California for that information. They're collecting it from state in the country. And I was on a call recently with the CDC Director, Dr. Frieden.

We shared with the group some general numbers that give you a sense of what we're dealing with nationwide. We estimated that about 3000 travelers had entered the US in the last month or so.

Of those 3000 travelers, we said CDC had consulted on about 600 to assist local and state health departments in the evaluation.

Of those 600 consults that has led to a total of 60 - 6-0 people who have actually had a blood test for Ebola. And of those, 3 have been positive. So that gives you a sense of the overall numbers at this point.

As far as the quarantine order, we've been working with all of you in clarifications and answering questions. The (JAYOCK) has received actually I believe a total of 175 questions since we started receiving the questions.

Not just on the quarantine order itself, but in general. And we have answered all but 13 of those questions at this point. Apologize to those 13 folks or questions that are still remaining, but we're working on them.

Working to get all the questions answered that come through the (JAYOCK). At this point I'm going to ask (unintelligible) just to give an update on some future thinking (unintelligible) order.

Woman: (Unintelligible) on our legal office, we're working on just a basic tool to assist local health offices and submitting our quarantine order.

Right now we're considering model orders which just save the basic authorities for local health officers. And we'll continue - parameters or some type of option for supply (unintelligible) with a point to mobile site.

I, also developing a checklist to assist the local health officer in their assessment of the risk level of the patient. And hopefully we'll be able to connect that with an appropriate order with our model.

And these will just be voluntary at this time. Also, they'll be voluntary so that if your local county council has additional thoughts, they're more than welcome to develop those orders.

We're here to help, so if there are other questions that those questions can get directed to me or someone else in our legal office. And then (unintelligible) refer to assist them in that.

Dr. (Ron Chapman): And we'll be seeking feedback from CCHO and (CHEACK) before we send out the model order tools for all of you. So, thank you.

Woman: Great.

Dr. (Ron Chapman): That's it.

Cheryl Starling: Thank you both. Let's move onto Dr. (Watt). Would you talk to us about the ongoing monitoring of travelers and new updates on that please?

Dr. (Watt): Sure, thank you Cheryl. So I just wanted to elaborate a little bit on what Dr. (Chavez) led off with. Just to remind folks that CDC has defined four risk categories.

The highest risk is what they're calling high risk. This is somebody who has had direct contact with someone with Ebola or with a dead body of someone who had Ebola without personnel protective equipment in the last 21 days.

The next level is the some risk category. This includes people who have provided healthcare for people with Ebola in an affected country while using appropriate PPE.

And it also includes household members of Ebola patients who did not provide care or have direct contact with them. The next group is the low risk category.

This is people who have been in one of the affect countries. But have had no contact with an Ebola patient - no direct contact with an Ebola patient. Or who have traveled on an airplane with someone who had Ebola.

And then the last category is the no risk category. CDC has been flushing out their recommendations for monitoring of people in the high, some and low risk categories.

They recommend daily monitoring of all three of those categories. And the key thing that they've been sharing with us is that for the people in the high and some risk category, they are recommending what they they're calling direct active monitoring of these people on a daily basis.

And by direct, they mean some sort of either in person or video connection where they're - so somebody is actually looking at the patient.

And the objectives of that - we sort of explored with them sort of what the purposes are for that.

And what they're saying is they really want to have somebody look at the patient and visually make an assessment of their wellness. And their concern that people may delay in reporting the very earliest symptoms.

And their hope is that by somebody looking at them, they can really probe a little bit and say, gee, you know, are you sure you're feeling well? Or, are you, you know, beginning to get sick?

So that's really the objective of this direct visualization of the patient at least once a day. And in support of that, they have been daily contacting us about the one individual who is in the some risk category in California.

They would like daily reports from us of the status of anyone who is in the high or some risk category. And as (Gil) said, they would also like weekly aggregate reporting of all of the people who are under monitoring.

So we are in the process of developing some systems for collecting those data from you - and should be hearing more about that in the coming days. We'd like to do that in such a way as to make it efficient for everyone.

Switching gears a little bit, we know that many of you have been working hard to develop plans for follow up of returning travelers. Certainly folks who have already had these folks have plans in place.

And very importantly that many of you are working with local EMS agencies around plans for transport and evaluation. We have developed some tools that we hope to get out to you soon.

One would be a catchment map for the five UC hospitals. And other is a document that describes the components of - that need to be in place for a local plan.

So that you can take a look at your planning and make sure you have all the pieces in place. One of the things that is evolving is the dialog with the UC's.

And an issue that has come up in some of our conversations with local health departments has be plans for evaluating people who may be returning travelers.

Maybe in a low risk category, who have some symptoms that require medical evaluation but are very unlikely to have Ebola?

And so many counties have been thinking through identification of local hospitals that can do an evaluation. That are prepared to manages somebody who is a returning traveler.

But you know, it hasn't reached that threshold where there's a feeling that this really a high risk person that should be directly transported to a UC. And so I just wanted to put that on table.

This is kind of an evolving situation in terms of what those thresholds would be.

But I wanted to encourage folks to be thinking about the possibility of having some local resources that could evaluate somebody who is a low risk and low likelihood.

But who has in fact been in an affected country within the last 21 days. That has a couple of important features. One is that it could be potentially done for expeditiously.

And it would also relieve concerns about overburdening the UC hospitals. So look for that document with some additional guidance from us also in the coming days.

So I think I'll stop there, back to you Cheryl.

Cheryl Starling: Thank you Dr. (Watt). Dr. (Chapman), would you talk to us about strategies for referrals with identified hospitals?

Dr. (Ron Chapman): Sure. So as Dr. (Watt) said, this is (Ron Chapman). As Dr. (Watt) said, we are working on a catchment area map and guidelines for referrals to the five UC's.

I've just reviewed those documents. We're also sharing today with the EMS authority, Dr. (Backer). Because we want to make sure those catchment areas are correct.

They appear to overlap with some of the trauma regions and trauma catchment areas. We want to make sure that it makes sense to our EMS colleagues as well.

I think, you know, I'm going to step back for second in terms of the identification of hospitals.

First, we've had a few questions about the UC's and other hospitals that may feel like they're prepared to care for patients with Ebola.

One of the questions we've heard is why don't we simply send people to one of these four hospitals nationally that have been identified by CDC?

Who we've seen in the press have been caring for patients over the last couple months. And I first want to just make it very clear that the CDC - the federal government has told all states that they need to identify hospitals within their states prepared to care for people with Ebola.

They feel like these four hospitals simply do not have the capacity to you know, care for numbers of people with Ebola. So they have really encouraged and pushed states to be prepared that way.

The other question that we keep getting is about other hospitals beyond the five UC's that may be prepared.

And we only have made public these five US's, but we're aware that other large systems in the state are preparing to care for people with Ebola.

I think some systems feel like they want to keep a person with Ebola within their own system. Not take for example, patients from outside of their system.

And they're preparing for that. So I would encourage you at the local level, if you, you know, have hospitals that are in those large systems like Kaiser, Sutter, Dignity and others.

To be in touch with folks to be clear about if a person within that system suddenly was identified with Ebola, where would those hospitals preferred those people to be transferred?

And again, I know some of those very large systems are working out those details within those systems.

None of this has been made public, but I think it's really important for you at the local level to connect with those hospitals and systems. Thank you.

Cheryl Starling: Thank you Dr. (Chapman). Dr. (Watt), may I ask you to talk about the Ebola rapid test? There have been several questions from local health departments about possible rolling this out.

If you could help us understand that please.

Dr. (Watt): Sure. So two updates in the laboratory - arena one is that we've heard that the CDC is now saying that if a state or local public health laboratory that's doing the CDC PCR test, has a negative result.

That can be considered final. So they're not requiring confirmation of negative test results now for tests being done at state and local public health laboratories.

The other update is that is that last week the FDA provided an emergency use authorization for a rapid Ebola test that could be done in hospitals.

This is a test that uses a commercially available testing platform - rapid testing platform that many hospitals already have for other assets. There have a couple of questions about this test.

And we're still getting information, but the test does a few limitations. And let me share those with you. We recently got some preliminary information about the assets test sensitivity.

It does appear to be less sensitive than the CDC issued PCR test. So it's about a log less sensitive in terms of the level of viremia that you need to have in order for it to turn positive.

All the FDA licensure indicated that all results using the rapid test have to be considered preliminary and require confirmation by the CDC assay.

And the other issue that's out there is that the test does not come from the manufacture with any reagents that can used for proficiency testing and making sure that the test actually works.

In order for a laboratory to stand this up, they actually have to do some preliminary testing using known samples in order to go ahead and start using it. And those known samples are not available.

And so there's some questions about whether in fact labs could actually even do this and do the required initial testing. So, you know, thinking about this practically, it's not quite clear what the added value of this rapid test would be.

If you have a negative test, particularly in early in the illness - and that's when you'd really want to have a rapid result.

Because it's less sensitive than the CDC test, there's a greater concern that you may have a false negative initially while viremia is still low. So an initial negative test may not be that useful.

And probably wouldn't add much to having a specimen go to a state of local lab. An initial positive test would be useful I think.

Would trigger clinical actions, but again, it's not clear whether the practicalities of getting this test online are really going to be worth that. So, that's the update there and back to you Cheryl.

Cheryl Starling: Thank you Dr. (Watt). We're going to defer the hospital preparedness presentation today. And Dr. (Sharon), would you give us an update on personal protective equipment?

Dr. (Sharon): Sure Cheryl. And we are going talk about CHALO interim guidance for Ebola virus in inpatient hospital settings. This is expected to release shortly. And you know it's been coming and it is coming.

And so I'll give a brief high level overview of what will be in it. There's active employee involved in the exposure control plans. It's required that there be written plan.

There would be an initial patient contact section. There would be the discussion of personal protective equipment requirements - including protection of the body, hands, eyes, nose, mouth.

There's obviously the respiratory protection requirements - the dawning, doping and decontamination requirements.

The precautionary removal protection for those staff who were involved in helping employees to remove the equipment - and the requirement content of training and the training must be interactive.

Though in many ways, it mirrors the CDC's guidance. However, Cal/OSHA has the ITD standard from 2009. And that goes to a higher level of respiratory protection.

So the executive group from the two agencies has been meeting. And we're trying to come to some agreement about the use of N95 as an alternative for the lesser level of criticality of care.

But this will just be the interim guidance for hospital care. The remaining guidance for other settings is still to be coming. And we hope that these will be forth coming, Dr. (Chapman), Friday? We don't know.

Now, I want to mention one other thing. It's just a Segue before we get into the questions. We know that many of your questions pertaining to the 13 that were unanswered are on the mortuary side and on the law enforcement side.

And we are looking into those. And so we don't have you know, that all (unintelligible) out for you yet - so many of your questions where pertaining to that, we're looking into that now. Thank you.

Cheryl Starling: Thank you, Dr. (Sharon). At this time, we'd like to open the intercom for questions. (Julie), if you could prepare to open for questions.

Just as a reminder, please be sure to give your full name and the organization with which you work when you ask the question. (Julie), would you introduce the question?

Operator: Yes. If you'd like to ask a question, you can press Star 1 and please record your name. The first question is from Cameron Kaiser from the Riverside County Department of Public Health.

Dr. Cameron Kaiser: Hey (Ron), this is Cameron Kaiser. I have two questions for you. The first one is - and this is just sort of a clarification. You said that you coming up with criteria for the UC's.

I was under the impression the UC's would not except somebody who was not a confirmed case. So if you could just clarify that.

And then the second one is - this is sort of a discussion that came up while we were doing all of our hot wash yesterday on one of our local false alarms. The base hospital was going to initial refer that patient out of jurisdiction.

Now if they were actually a - somebody in that case definition as far as I'm concerned, I would of immediately verbally put them under an isolation order - which means if they left the jurisdiction, they've just broken the law.

Are we working on ways to sort of streamline that? So what's the base hospital involvement? What are your thinking's there?

Dr. (Ron Chapman): So I'll take the first question. And then may be, you know, (James) or Cheryl on the second question. In regards to the first question Cameron, we've been in discussion with the system.

And there is an open (unintelligible) to except a patient who is very high risk and highly suspect to have Ebola.

The UC's are very worried about entering the flu session and being shipped a bunch of folks that just, you know, don't have the risk factors. You know, maybe they're from South Africa or who knows where.

We've had one instance for example where I think somebody was from Gouna and they thought it was Guinea. And that got everybody all you know, dizzy, whatever.

So the UC's have shared with us the contact - the duty officers for the UC's. But we're coming up with this guidance for all of you and for EMS to understand how the system will work.

I think one of the keys is, you know, if you have anybody you're monitoring - any traveler that you're monitoring that suddenly develops symptoms. And with flu season approaching, it's likely it's going happen.

Then you know needs to be immediate contact with us and together coordinate where the most appropriate place is going to be for that person to be transferred.

And so those details are going to be in the guidance that we're going to be putting out.

Dr. (Gil Chavez): And just to add a little bit to that - this is (Gil). That you know, in talking to the health officers in counties where travelers are being monitored.

It's good to know that the great majority of them already have plans in place for using some of their local hospitals to do the initial assessment.

So that will relieve the pressure of having to transfer people directly to UC. However, there may be instances where county may not have the ability to transfer somebody to a local hospital for evaluation if it is one of those travels that is being monitored.

And so we're working with those few counties in looking at ways in which we can have relationships with neighboring counties that may have that capability.

Or that may be one of those instances where direct transfer to UC for evaluation may be the only recourse we have. So that's what will be covered in our upcoming guidance.

Cheryl Starling: Thank you. And I apologize, we don't have our LEMSA partners on line. But Dr. (Cameron) - I mean Dr. Kaiser, one of the things is I'm concerned that the base hospital was directing a suspected Ebola patient at all.

Did EMS not immediately notify your process within the county that a suspected Ebola? They should not be moving a patient at all, and definitely not allowing the base hospital to direct traffic.

And so we can talk offline more, if you like about this? And get our LEMSA partners involved in the conversation.

But primarily, that patient shouldn't have moved from their original location without contact to the local health department.

Dr. Cameron Kaiser: Yes, we're still trying to sort of figure out all the moving pieces that happened there.

But I just want to make sure that if - there's also the political concern of a nearby jurisdiction saying why are you bringing a potential (unintelligible) over there.

So I want to make sure we avoid that potential as well.

Cheryl Starling: Well I'll tell you what, if you'd like, I'm happy to contact you offline and bring our LEMSA partners and we can have a discussion? But it sounds like you need to kind of get to the root of why is slipped through the cracks.

Dr. Cameron Kaiser: We'd appreciate that, thank you.

Cheryl Starling: Okay, thanks. (Julie), may I have the next question please?

Operator: Yes. The next question is from Janet Berreman, from the city of Berkeley Health Officer.

((Crosstalk))

Cheryl Starling: Hi, what's the question?

Dr. Janet Berreman: I have two questions that are both about monitoring arriving travelers. The first one is, I understand that notification of any arriving travelers comes by phone and email to the local health department.

And I'm wondering if that's a seven day a week, 24/7 operation or if there's some predictability to that? And I'm also wondering what contact information you using for the local health departments?

You know, do you have 24/7 contact information for us? Is it the health officer? Is it someone else in the local health department? That's all the first question.

Man: (James), do you want to take that?

(James): Sure. So the answer to the first question is yes, this is a seven day a week process. The EPI-X notifications come into us at different times during the day.

We have folks seven days a week who are looking for those. And then as soon as they pick one up, they would be in touch with the local health department.

We do have 24/7 contact information for each local health department. I don't have the details of exactly which numbers there are. We'd be happy to check in with you offline - Berkeley.

But we have that that we use for a variety of our different duty officer systems.

Dr. Janet Berreman: Actually on the CCLHO exec call this morning, (Lea Northrop) was going to, you know, circulate the list that she currently has and updated.

And then work with getting, you know, making sure that CD page the most recent information for all the jurisdictions. Rather than doing it one by one - so thank you.

Cheryl Starling: And Janet, this is Cheryl. If I can amplify, we have updated our CD controller list. And we have 24/7 numbers for all of our CD controller...

Dr. Janet Berreman: Okay.

Cheryl Starling: ...county by county. And (unintelligible) just updated that. And made sure - you're welcome to email (Lea) and I will confirm to make sure we can give you want we have.

But we primarily contact first the CD controller. Should the CD controller not be available or somehow doesn't call us back. Are next think is to go to the 24/7 number at the local health department.

And contact someone until we get a person on the line - so first point of contact is CD controller.

Dr. Janet Berreman: That's perfect. I think that recently updated CD controller list is great. And I'm glad to know that that's what you're using.

My second question is in reference to (Gil), you mentioned that there was a conference call earlier in the week. At which the counties who are currently monitoring people discussed their lessoned learned.

And I wondered if there's a plan to share those lessons learned with the rest of us, so that we don't have to learn them over again when we are in that position?

Man: That's a very good question Janet. And I'm afraid that we were focused on discussing and I don't know that we had exceptionally good notes.

But I think going forward; we can attempt to take notes on those calls so we can share with all of you.

Cheryl Starling: And if I may amplify that? We are also asking those 14 counties that do have written protocols, to provide us with traveler protocols.

And we hope to get those and put together a best practices document that CDPH can distribute to the counties. So you can actually see what other counties are doing for best practices.

Dr. Janet Berreman: Great, thank you.

Cheryl Starling: (Julie), may we have the next question please?

Operator: The next question is from Eric McDonald, from the county of San Diego.

Dr. Eric McDonald: Yes. Actually I just wanted to go back and ask if the information about the model health orb officer orders could be repeated - when Dr. (Chapman) and the legal individual were talking.

At least from my end, I was getting a very broken up reception. So, if we could just hear when those revised model orders will be disseminated, that would be useful.

Woman: Well the plan right now is to confirm with our partners, which would include (unintelligible) and CCLHO before we disseminate it to a larger audience.

So I would say that probably within the next week or so, we'd be able to get something out there for comment.

Dr. Eric McDonald: Well thank you very much.

Woman: No problem.

Cheryl Starling: Thank you, Dr. McDonald. (Julie), may we have the next question?

Operator: The next question is from Dr. Eric Rudnick, from the Santa Clara County EMS.

Dr. Eric Rudnick: Good morning - thank you. I'm actually one of your EMS partners. My concern actually is for the LEMPSA they have in rural northern California. And it really goes to margining these monitored travelers.

We have multiple small critical access hospitals who have no ICU and incredibly limited resources. And our EMS providers are very small. And in my opinion, it's not feasible to keep patients that are maybe of some risk.

Who have you know, either been in one of the affected countries. And so we in the local health departments are trying figure out do we bypass our small critical access hospital and have our EMS crews do directly to another hospital?

We are about 2-1/2 to 3 hours away from UC Davis. And so where are we at getting other regional resources so a small critical access hospital that once they reach out to CDPH and it turns out to be somebody who's still at some risk.

How we get them to a regional hospital?

Dr. (Travis): Yes, so this is Dr. (Travis). The first thing, just to put things into perspective is that we are fortunate so far that the - all of the travelers that are arriving in California from the affected areas are within, you know, an hour drive of any of the UC hospitals.

So that's allowing us to really have some piece of mind that the great majority of the people that maybe at risk for having Ebola are actually within very, very reasonable distance of any of our UC's.

I think the great majority are in larger counties, in larger urban areas. A couple of them are in more - not so urban counties, but say within an hour drive from UC's.

So we believe that that's going to account for the great majority of the real Ebola risk patients we may have.

Not to say that there's not, you know the possibility of an unforeseen individual showing up in an emergency department somewhere else. But that's what we're trying to minimize.

One of the things that we have asked each of the local health officers is to have a very specific plan on how to deal with the travelers situations. So we're reaching out to each one of you that has monitoring in place.

So we know what you plan to do with those individuals. And I think that's pretty clear cut. I think for others that may not have travelers yet, we've been asking for sort of the something.

In terms of, you know, how would you triage a patient that shows in your doorstep in a hospital? And how would you transport that individual?

I think that's where I think as you clearly articulated, the next challenge we have to deal with. Our goal is that each county has done an assessment of their hospital capacity.

And can honestly tell us if they feel like they have zero capacity in a county to triage a patient.

Because then we need to really make plans for where else we would go with individual patient if they don't have a place to evaluate him or her.

Cheryl Starling: And I understand Dr. Baker, you're on the line from the EMS authority? If you could very briefly get answer and perhaps you can circle back with Dr. Rudnick on - offline?

Dr. Jason Baker: Yes. I think we have some strategies that (Eric) related - yes, similar to trauma and some of the other regionalized services. That we need to find a hospital that can support you for the different levels of risk of patients.

Dr. Eric Rudnick: The only follow up I have is getting from the hospital is one issue. I'm wondering about regional I darts - because many of my small providers in Norco have three or four ambulances.

And if one of them is taken out of service, that critically impacts the entire region. And I can talk to Dr. Baker offline, but having one of their ambulances taken out of service - losing a quarter to a third of your fleet would severally impact.

Dr. Jason Baker: I agree. I think the EMS system will have to work much like the hospital system. And not all providers are equal and so we will have to regionalize that as well.

Cheryl Starling: So I encourage you two to connect offline and further address this question. Because I know EMSA is working on it. So thank you, Dr. Rudnick.

Dr. Eric Rudnick: Well I have one more quick question and that is the health officer. If we're going to do a regional system - well actually never mind, I withdraw the question. I'll talk to Dr. Baker offline, thank you.

Cheryl Starling: Sounds great. Thank you Dr. Rudnick. (Julie), may we have the next question?

Operator: The next question is from Rick Johnson, from Mono County Health Department.

Cheryl Starling: Good morning.

Dr. Rick Johnson: Good morning, this is Rick. I cover rural areas much like Eric does. And couple of questions. One is regarding getting a patient who calls 911 - let's say who was monitored to the hospital.

We have one hospital in our area that would not be setup to monitor a patient - I'm sorry, to initially evaluate a patient. And I'm wondering what needs to be done other than dealing with the LEMPSA and the medical director.

To have a system in place where the ambulance can bypass the usual destination and go to a hospital that is able to do the initial evaluation?

The second thing is, you know, like Eric has shared, our providers would be really stretched to do anything more than a regional approach to get a patient to hospital for evaluation.

But let's say we have a high risk monitored patient or a patient who now is confirmed as with a positive Ebola test. And we are five or six hours away from any of the UC hospitals that you're talking about.

Are we expected to gear up and have our local EMS providers - whether that's regional or whether we have an I dart of not to do that?

Or can we expect some help from outside the area from the state - form EMSA - from CDPH - from the National Guard?

How would that all work in getting a patient from a remote area to one of the UC hospitals?

Cheryl Starling: Dr. Baker, could we ask you to answer that question?

Dr. Jason Baker: Yes, hi Rick. We haven't been - we have had discussion with the National Guard and they are willing to fly their larger helicopters to do this.

The other area ambulance companies are not willing to transport a patient because of decontamination issues. The condition that put on that though, is that the patient would have to be in one of those transport isolation chambers.

And so we're pricing those and looking at where we could get the money to invest in one of those to support the rural areas.

Dr. (Ron Chapman): (Howard), this is (Ron). Can you speak to AMR experiences and the work that you all are doing with those folks?

(Howard): Well AMR is the one provider in the state who actually has the experience transporting confirmed patients down in Texas. And I think they also transported in Nebraska.

So they are working with us, but they've only ground transports as well. The only air transports have been with these special outfitted CDC transport plan. And we have not confirmed that there are domestic providers at this point.

You can do short hauls instate. So we are going to have to rely on the National Guard for that. Because we've been told that it's just unreasonable to expect people - providers to stay in the PPE for that long.

Dr. Rick Johnson: So would it be reasonable to think that AMR could send one of their specialized units into a rural area that they normally do not serve - to pick up a patient to go to a UC hospital?

(Howard): We fully expect that some of the services will have to be regionalized. And we're going to have to look at exemptions from the usual exclusive operating areas, if that's what you mean.

Dr. Rick Johnson: Yes. Thanks (unintelligible).

Cheryl Starling: Great, thank you Dr. Johnson. (Julie), may we ask how many more questions are in the queue please?

Operator: Right now there's five.

Cheryl Starling: Right. Okay, (Julie), we still have some time. Please go with the next question.

Operator: The next question is from Nikki Green from the L.A. County Public Health Lab.

Nikki Green: Hi. My question - I have one question and one comment. My first question is, has the state gotten any guidance from CDC if we do have a positive Ebola patient?

What is the frequency and timing of testing for Ebola clearance? And what is the acceptable specimen type for that?

Cheryl Starling: Dr. (Watt) and or Ms. (Hacker), are you able to answer that question?

Dr. (Watt): Sure. This issue hasn't come up to my knowledge. I do know that testing has been done the previous Ebola patients as they are, you know, entering into convalescents.

They have a series of tests to sort of clear them for release from the hospital. But I don't know that - I haven't seen a protocol in that. And (Jill), are you on the phone? Have you seen anything on that?

(Jill): I am here and Nikki, I've not seen anything that identifies how often the specimens are being tested.

Nikki Green: Right, or like they have to have like three negatives or five negatives. You know how like if you have a salmonella clearance; you need a certain number within a certain timeframe - something like that.

((Crosstalk))

(Jill): Yes (unintelligible) released about that. But we can certainly inquire.

Nikki Green: Yes. And then I just had one comment about the bio (unintelligible) assay, because I know - at least here in L.A., we've getting a lot of hospitals asking me questions too.

In my own opinion, I have not been recommending that they go forward this, because it requires them to have additional sample manipulation. And basically if they can't validate it under clear regulations, it becomes RUL.

Which means that actually should not be reporting this for diagnostic purposes at all. So even if they got a positive, they would have to report that out as research use only.

Which technically means that result could not be acted up - and no matter if it's positive or negative, it still has to go to public health for testing.

Woman: Well Nikki, the guidance for use of the bio fire is - for the terms of the emergency use authorization, is that - those results can only be used for presumptive diagnoses.

There not to be used for patient management. So any assay - any result that a clinical laboratory would get from that assay, you would still need to verify their result.

Nikki Green: Right.

Woman: So it's unclear what the use of this assay would be.

Nikki Green: Yes. Is the department going to be giving these out? Because I heard that New York State Department is going to be I guess acquiring these for different hospitals.

Is California State doing the same thing?

Dr. (Gil Chavez): Nikki, this is (Gil). We don't have any plans to do that at this point. I think our folks as first had a little questions about the utility of this and how much in fact it will help us manage patients.

So until we have that, assurance that in fact this is going to help hospitals in some way better handle patients, we have no plans on providing those to hospitals.

Nikki Green: Okay. Thank you.

Cheryl Starling: Thank you. (Julie), may we have the next question please?

Operator: The next question is from Kevin Rose, from San Mateo County EMS.

Kevin Rose: Hi, good morning. More of just a logistics question on the conference calls. I have some colleagues who are not able to make the 10 or the 11 o'clock.

Is there a site where the recorded calls are posted that folks might be able to go to access?

Cheryl Starling: Thank you for your question, Kevin. We will not be posting the recordings. We do intend to put out minutes - of course minutes and priorities. We are trying hard to get the minutes done so that they can be posted.

Please check our Website, that when we have them available, they'll be posted.

Kevin Rose: Okay, thank you.

Cheryl Starling: May we have the next question?

Operator: The next question is from Erica Pan, from Alameda County Health Department.

Cheryl Starling: Hi Erica, what's your question?

Erica Pan: Hi. I just wanted to follow up on the mention of - which I think is great, some upcoming guidance about you know, as we have some low or some risk travelers that we're monitoring.

If they have low suspicion symptoms or symptoms that are not compatible with Ebola and trying to get them evaluated. Are the recommendations going to be to use the same high level PPE as in the inpatient setting?

Or are there going to be recommendations about the PPE's for evaluation of those patients?

(Kevin): If you're referring to travelers who are asymptomatic, there are no special recommendations for people who are asymptomatic.

Erica Pan: The travelers who are some or low risk, but they are symptoms that are not you know, it was already mentioned that we're going to need to potentially evaluate them if they have just URI symptoms and no fever.

Or they're coming in for you know some other symptom that's not compatible with Ebola symptoms that might need to be evaluated. Are we going to have some of those (unintelligible)?

((Crosstalk))

(Kevin): If they have (unintelligible). If they have clinical - this is (Kevin), (Sharon). If they have clinical symptoms that are in any way shape or form - suggestive of a possibility of Ebola, then personal protective equipment should be worn.

And it could be of the nature of the N95 mask and the coverall type of situation. Now you know, you probably don't need the (papers) if somebody is in a very low level situation.

And that's the kind of discussion that we're having with Cal/OHSA about what type of personal protective equipment is needed in those low level situations. Thank you for the question.

Erica Pan: Yes, thank you. It would be great to have some official guidance because that's the biggest question from our outpatient providers.

Cheryl Starling: Great, thank you Erica. (Julie), may we have the next question please?

Operator: The next question is from Karen Holbrook, from Sonoma County.

Karen Holbrook: Hi, thank you. My question harkens to us assessing our local hospitals. And a couple weeks ago, you mentioned that the state was doing a survey of all of the hospitals and would be getting the results back out to us.

I haven't seen that. Have I missed it? Is that forthcoming? And if it's not, then perhaps we could have the tool that you were using so that we could that independently?

And then the second request, is I've asked - been asked by my hospital is there any guidance or protocols on terminal cleaning from a patient with confirmed Ebola?

I know Nebraska in Emory had some comments that they made during COCO call. But is there anything official or anything written out with regards to that that I can pass on to my hospitals? Thank you.

Dr. (Ron Chapman): This is (Ron Chapman). In terms of the survey results, that's on hold right now. And the assessment tool - has that been distributed?

Cheryl Starling: I believe that the assessment tool is located on our Website, Karen. So go the CDPH - click on the Ebola information link and it will take you to the page.

And it has been posted there.

Man: Oh, so they distributed to everyone?

Woman: Yes.

((Crosstalk))

Woman: No, the tool. The tools distrusted and Karen, I'll send you the link to the tools.

Karen Holbrook: Thank you.

Woman: (Ron), would you talk about the terminal cleaning? Aren't there any recommendations for terminal cleaning?

Dr. (Ron Chapman): Well I'm going to have to kind of defer that over to Dr. (Sharon) because it's more like decontamination rather than a waste (unintelligible). We're talking about reusable type equipment.

Dr. (Sharon): If we're talking about the cleaning of equipment, that will be specified in the Cal/OHSA guidelines. And that would be section F.

Karen Holbrook: It's the equipment - it's the total room. So it would be inclusive of the equipment. So I will look there.

Man: There's also some guidance for that on the CDC Website.

Woman: Yes.

Cheryl Starling: Thank you Karen for your question. (Julie), may we have the next question please?

Operator: The next question is from (Balo Mantas) from the Flannel County Health Department.

Cheryl Starling: (Unintelligible).

(Balo Mantas): Hello everybody. I had a comment and then a question. In follow to the bio (unintelligible) discussion, I think one of the challenges that has arisen in a lot of the counties and I think we've heard it echo on this call as well.

Is the desire to minimize exposure - potential exposure to healthcare workers in a community hospital setting. So what we're looking for are reasonable triggers to move a patient to one of the referral hospitals.

And in view of that, I think one of the roles that the bio fire testing can potentially provide value with, is an earlier opportunity to consider someone a high suspect.

And then arrange for transferred to a UC hospital. Because even though there is some potential for false positive and even though it requires - clearly requires follow testing with an approved platform in order to confirm.

It would none the less represent a very, very high suspect scenario - and would warrant transfer potentially a day or two earlier than would be the case with the current testing modalities.

And so I think we should at least consider it having value in that context. And then with regard to critical care transport of the patients from community setting to one of the refer hospitals.

Is there going to be a control transfer? So in consideration of catchment areas, clearly you want to send them to the closet available hospital.

But if that hospital is already dealing with an Ebola patient, we should make consideration for secondary and (unintelligible) transports.

And then in regard to that, it seems like there would be a good opportunity here for the state to engage (unintelligible) or some other state wide vendor in a contract - so that we would actually have pre-identified in limited numbers of (unintelligible) transferred vehicles used for that type of transport.

Cheryl Starling: Thank you for your question, (Balo). Dr. (Watt), can you make a comment on the bio fire issue of the lab?

Dr. (Watt): Yes. You make a good point (Balo). And you know, that is I think the one scenario where there - or to me, there could be value.

And I think the question is whether the logistics involved of dealing with the efficiency testing of the assay (unintelligible) that all work. But that could be a situation where it makes sense.

And I also wanted to respond to your suggestion about, you know, back up hospitals for treating Ebola patients. And that's a really good point. And that's something that we are planning to do.

Where you would be looking at all of the folks who have been transported to UC's and you know, making assessments. Working with the UC's as to whether which facility would be the most appropriate.

Taking into account what the others are already dealing with.

Cheryl Starling: Thank you, Dr. (Watt). Dr. Baker, would you talk about the possibility of engaging EAMR?

Dr. Jason Baker: It's for - well, AMR is the one - biggest company that has experience. We don't know how - they already are the contracted provider jurisdictions around the state, you know various jurisdictions.

We don't know how far they're willing to go outside of their areas. But there are other larger providers also stepping up. So just as we're looking at (unintelligible) map for catchment areas for the various UC hospitals.

I think we're going to - on the basis of this call, it's clear that we're going to need to develop a map of catchment areas for potentially designated ambulance areas.

So we're going to have to start that discussion and see if the companies that are willing and stepping up to transfer, are willing to go outside of their area.

And that means as anyone who's involved in the EMS knows, that you need some delegate negotiations around operating areas, but we will begin those discussions.

Cheryl Starling: Thank you. At this time, I apologize if we did not get to your question, but we are going to end the call at this.

On behalf of CDPH, I would like to thank everyone for your ongoing efforts in this Ebola planning and response situation. And we look forward to speaking to you on our next call.

As a reminder, please if you have a question that did not get answered or have questions, you can contact jeocuser43@cdph.ca.gov. Again, thank you for coming on the call.